TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
James Weiss, M.D.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-16-3389-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Service codes and CPT codes are not to be bundled nor compounded and are to be billed and reimbursed separately and independently from one another."

Amount in Dispute: $285.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "A4556 Supplies normally used to complete the nerve conduction study should not be billed separately
Level of E&M is Not Supported By Documentation – per CPT guidelines"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2016	Evaluation & Management, new patient (99204)	$260.90	$0.00
January 22, 2016	Needle Electromyography (95886)	$0.00	$0.00
January 22, 2016	Nerve Conduction Studies, 7-8 studies (95910)	$0.00	$0.00
January 22, 2016	Electrodes, per pair (A4556)	$25.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - W3 – Request for reconsideration
   - 97 – The benefit for this service is included in the payment/allowance for another service procedure that has already been adjudicated.
   - 193
   - P12

Issues

1. What are the services in dispute?
2. What are the applicable rules for this dispute?
3. Is New Hampshire Insurance Company's reason for denial of payment for procedure code 99204 supported?
4. Is New Hampshire Insurance Company's reason for denial of payment for procedure code A4556 supported?

Findings

1. James Weiss, M.D. included procedure codes 99204, 95886, 95910, and A4556 on the Medical Fee Dispute Resolution Request (DWC060). Dr. Weiss is seeking $0.00 for procedure codes 95886 and 95910. Therefore, these services will not be considered in this dispute. Dr. Weiss is seeking $285.90 for procedure codes 99204 and A4556. These services will be reviewed in accordance with applicable rules and guidelines for this dispute.

2. Reimbursement for the disputed codes is subject to the fee guidelines for professional medical services found in 28 Texas Administrative Code §134.203(b)(1), which states, in pertinent part:

   > for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
   > (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

3. New Hampshire Insurance Company denied disputed procedure code 99204 with claim adjustment reason codes 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION," and 97 – "THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED." The division finds that procedure code 95910, billed by Dr. Weiss on the same date of service, has a global status of "XXX." Chapter I of the General Correct Coding Policies for *National Correct Coding Initiative Policy Manual for Medicare Services*, section D, effective January 1, 2016 states, in relevant part:

   > Many of these "XXX" procedures are performed by physicians and have inherent pre-procedure, intra-procedure and post-procedure work usually performed each time the procedure is completed. This work should never be reported as a separate E&M code … **With <u>most</u> "XXX" procedures, the physician may, however perform a significant and separately identifiable E&M service on the same date of service which may be reported by appending modifier 25 to the E&M code** [emphasis added]**.** This E&M service may be related to the same diagnosis necessitating the performance of the "XXX" procedure but cannot include any work inherent in the "XXX" procedure, supervision of others performing the "XXX" procedure, or time for interpreting the result of the "XXX" procedure. **Appending modifier 25 to a significant, separately identifiable E&M service when performed on the same date of service as an "XXX" procedure is correct coding** [emphasis added].

   Review of the submitted documentation does not find that Dr. Weiss appended modifier 25 to procedure code 99204 in the billing process, signifying that the service was a significant, separately identifiable evaluation and management service. Therefore, New Hampshire Insurance Company's denial reasons are supported. Reimbursement for this service cannot be recommended.

4. New Hampshire Insurance Company denied disputed procedure code A4556 with claim adjustment reason codes 97 – "THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER

SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED." The division finds that CPT Code A4556 is a Bundled/Excluded code, which means:

> There are no RVUs and no payment amounts for these services. No separate payment should be made for them under the fee schedule.--If the item or service is covered as incident to a physician service and is provided on the same day as a physician service, payment for it is bundled into the payment for the physician service to which it is incident. (An example is an elastic bandage furnished by a physician incident to physician service.)--If the item or service is covered as other than incident to a physician service, it is excluded from the fee schedule (i.e., colostomy supplies) and should be paid under the other payment provision of the Act.

The Medicare Benefit Policy Manual, Chapter 15 §60.1 states, "Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness." The electrodes are incident to the physician services furnished the same day, therefore, they are bundled in those services. New Hampshire Insurance Company's denial reason is supported. Reimbursement for this service cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 22, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.